

Supervisor First Report of Accident

A. Employee Responsibilities: Employees shall immediately report all workplace accidents/injuries and incidents (unanticipated events with personnel injury potential) to their supervisor.

B. Supervisor Responsibilities:

1. **Accident Response:** The immediate concern of management shall be to ensure that an injured employee is provided necessary and appropriate care. The Supervisor has primary responsibility for managing this response.

2. **Reporting:** Ensure that all workplace injuries are promptly reported to the site Workers Compensation Manager.

3. **Accident Investigation:** Complete a Supervisor First Report of Accident within one working day of the accident. Separate witnesses from each other to insure an unbiased account of accident details. Remove or restrict access to any equipment or other physical evidence involved until it can be examined. Forward a copy of the report to the Workers Compensation Manager if an employee has been injured.

4. **Hazard Correction:** Correct hazards identified during the accident/incident investigation.

C. Report Management: The site Workers Compensation Manager shall be responsible for maintaining a copy of the completed Supervisor First Report of Accident in the appropriate employee file and shall forward copies as per management policy.

D. Reporting Serious Injuries: The designated management representative shall report to OSHA, within 8 hours of occurrence, all work-related fatalities and within 24 hours, all incidents involving employee in-patient hospitalization, amputation, or loss of an eye.

E. Review and Assessment: The Safety Committee should review accident/incident reports during each Safety Committee meeting and should use these reports to assess the adequacy of or need for additional corrective action including additional employee safety training.



Supervisor First Report of Accident

It is company policy that all workplace accidents, injuries and incidents (unanticipated events with personnel injury potential) be reported immediately.

Accident Date and Time:	Date and Time Reported:	Was Anyone Injured? Yes No	
Injured Employee Full Name:	Job Title:	Department:	
First Aid Administered By:	Medical Care Authorized By:	Medical Facility Referred to:	
Accident/Incident Location:		Equipment Involved:	
Description of Accident: (attach photos to aid description)			
Apparent Cause of Accident:			
Possible Contributing Factors:			
Witness Name(s): (attach additional sheet for each witness statement)			
Actions Needed To Prevent Recurrence:			
Supervisor Signature:	Date:	Employee Signature:	Date:
Supervisor Print Name:		Employee Print Name:	

Note: If employee injury is involved, forward completed report to the Workers Comp Manager



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Accident Witness Statement

The information contained on this form will be used to help identify the cause of this accident. The form should be completed by any witness to the accident and submitted with the Supervisor's First Report of Accident.

Accident Date and Time:	Date and Time Reported:	Was Anyone Injured? Yes No
Injured Employee Full Name:	Job Title:	Department:
Explain what you saw.		
What type of injury occurred to the employee?		
Describe any factors contributing to the accident that you observed?		
Additional comments and information		
I verify that I witnessed the accident as described above. The statements made were given by me freely, without coercion from my supervisor or the injured employee.		
Witness Name	Phone number or email address	
Witness Signature	Date	



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